Office use only			
Signed & Dated ☐	Faxed ☐		
Visa & Passport ☐	Scanned ☐		
NHI ☐	Text C ☐		
Request Notes ☐	Portal C ☐		
Enrolled ☐			
Entered ☐			

AUCKLAND FAMILY MEDICAL CENTRE

PATIENT ENROLMENT FORM

ProCARE

Dr Sheelagh James - #16157 ☐
Dr John McCartie - #13621 ☐
Dr Phillipa Murray - #18233 ☐
Dr Rebecca Little - #69391 ☐
Dr Mei Ling Lee - #20770 ☐
Dr Wei Long - #51193 ☐

auckfamc	94 Remuera Road, Remuera 1050	524 6249	524 5230	
EDI Number	Address	Phone Number	Fax Number	NHI *(Office use only)*

Legal Name	(Title)	Given Name	Other Given Name(s))	Family Name
Other Name(s) (e.g. maiden name) Please tick the name you prefer				
Birth Details		Day / Month / Year of Birth	Place of Birth	Country of birth
Gender	☐ Male	☐ Female	☐ Gender diverse (please state)	Occupation

Usual Residential Address	House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode

Contact Details	Mobile Phone **Do you wish to receive text messages yes no**	Home Phone	Email Address	
Emergency Contact	Name		Relationship	Mobile (or other) Phone

Community Services Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number
High User Health Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number

Are you a smoker? Yes No Never If yes would you like help to quit.

Transfer of Records	*In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register.*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Address / Location	

Ethnicity Details

Which ethnic group(s) do you belong to?
Tick the space or spaces which apply to you

- ◯ New Zealand European
- ◯ Maori
- ◯ Samoan
- ◯ Cook Island Maori
- ◯ Tongan
- ◯ Niuean
- ◯ Chinese
- ◯ Indian

Other (such as Dutch, Japanese

My declaration of entitlement and eligibility

a	**I am a New Zealand citizen** *(If yes, tick box and proceed to **I confirm that, if requested, I can provide proof of my eligibility** below)*	☐

I am entitled to enrol because I am residing permanently in New Zealand.
The definition of residing permanently in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months

I am eligible to enrol because:

If you are **not a New Zealand citizen** please tick which eligibility criteria applies to you (b–j) below:

b	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	☐
c	I am an Australian citizen or Australian permanent resident AND able to show I have been in New Zealand or intend to stay in New Zealand for at least 2 consecutive years	☐
d	I have a work visa/permit and can show that I am able to be in New Zealand for at least 2 years (previous permits included)	☐
e	I am an interim visa holder who was eligible immediately before my interim visa started	☐
f	I am a refugee or protected person OR in the process of applying for, or appealing refugee or protection status, OR a victim or suspected victim of people trafficking	☐
g	I am under 18 years and in the care and control of a parent/legal guardian/adopting parent who meets one criterion in clauses a–f above **OR** in the control of the Chief Executive of the Ministry of Social Development	☐
h	I am a NZ Aid Programme student studying in NZ and receiving Official Development Assistance funding (or their partner or child under 18 years old)	☐
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	☐
j	I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund	☐

I confirm that, if requested, I can provide proof of my eligibility	☐	Evidence sighted (*Office use only*)

My agreement to the enrolment process

NB. Parent or Caregiver to sign if you are under 16 years

I intend to use this practice as my regular and on-going provider of general practice / GP / health care services.

I understand that by enrolling with this practice, I will be included in the enrolled population with the Primary Health Organisation (PHO) this practice belongs to, and my name address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers.

I understand that if I visit another health care provider where I am not enrolled I may be charged a higher fee.

I have been given information about the benefits and implications of enrolment and the services this practice and PHO provides along with the PHO's name and contact details.

I have read and I agree with the Use of Health Information Statement. The information I have provided on the Enrolment Form will be used to determine eligibility to receive publicly-funded services. Information may be compared with other government agencies, but only when permitted under the Privacy Act.

Patient Survey

From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous.

Patient Survey Contact Details: As provided above ☐

I do not wish to participate in the Patient Survey ☐

I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

Signatory Details	Signature	Day / Month / Year	☐ Self-Signing	☐ Authority
Authority Details *(where signatory is not the enrolling person)*	Full Name	Relationship	Contact Phone	
	Basis of authority (e.g. parent of a child under 16 years of age)			

auckland family medical centre
Auckland Family Medical Centre
94 Remuera Road
Remuera

Auckland Family Medical Centre
New Patient Medical Questionnaire

Please complete one form for each member of your family and hand back to reception

Name:_____ DOB: / /

1. Do you have any, or have had any of the following medical problems? or is there a family history of the following:

	Self	Family		Self	Family
Diabetes	☐ Yes	☐ Yes	Blood clot	☐ Yes	☐ Yes
High blood pressure	☐ Yes	☐ Yes	Stroke	☐ Yes	☐ Yes
Heart disease or problems	☐ Yes	☐ Yes	High cholesterol	☐ Yes	☐ Yes
Heart attack <60yr >60yr	☐ Yes	☐ Yes	Migraine	☐ Yes	☐ Yes
Asthma	☐ Yes	☐ Yes	Epilepsy	☐ Yes	☐ Yes
Other lung or respiratory disease or problems	☐ Yes	☐ Yes	Breast cancer	☐ Yes	☐ Yes
Kidney disease or problems	☐ Yes	☐ Yes	Other cancer	☐ Yes	☐ Yes
Liver disease or Hepatitis	☐ Yes	☐ Yes	Glaucoma	☐ Yes	☐ Yes
Bowel disease or problems	☐ Yes	☐ Yes	Rheumatic Fever	☐ Yes	☐ Yes
Joint disease or problems, arthritis	☐ Yes	☐ Yes	Tuberculosis (TB)	☐ Yes	☐ Yes
Depression and/or anxiety	☐ Yes	☐ Yes	Eczema	☐ Yes	☐ Yes
Other mental health illnesses	☐ Yes	☐ Yes	Hay Fever	☐ Yes	☐ Yes

2. Do you have any other health, disability problems or inherited conditions? – *please list*

3. Please list any regular medications that you take

4. Have had any operations? ☐ Yes ☐ No *If yes, please list*

5. Are you allergic to any medications? ☐ Yes ☐ No *If yes, please list*

6. Do you smoke? ☐ No ☐ Yes If yes, how many/day _____
   If Yes – would you like help to quit smoking ☐ Yes ☐ No

   Have you ever smoked ☐ No ☐ Yes If yes, how much and for how long _____
   when did you give up _____

7. Do you drink alcohol? ☐ No ☐ Yes If yes, how much/week _____
   and what type _____

8. Do you have any substance abuse problems? ☐ Yes ☐ No

9. Women: (*those over 20 years & sexually active*)
   When was your most recent cervical smear? _____
   Have you ever had an abnormal smear? ☐ Yes ☐ No ☐ Don't know

   Have you had a mammogram (*those over 40 years*)? ☐ No ☐ Yes If Yes, when? _____

10. When was your last Tetanus booster?

11. Are your childhood immunisations up to date? ☐ Yes,if so where ? _____ ☐ No ☐ Don't know

IMMUNISATION RECORD: Please provide a copy of your immunisation record.

Signed:_____ Date:_____

If you enrolled and requested your medical notes to be transferred from your previous GP we wish to advise you that we will hold these securely for reference only. The notes will not be specifically reviewed unless you request us to, or unless the Doctor feels that your medical history warrants this. Please be careful to disclose all important medical/surgical/psychiatric information.

auckland family medical centre

Auckland Family Medical Centre
94 Remuera Road
Remuera
www.aucklandfamilymedical.co.nz

Auckland Family Medical Centre - Patient Portal Registration Form

Please complete this form and supply one form of photo ID to register for the Auckland Family Medical Centre patient portal.

Each person that uses the portal must have their own unique email address.

Full Name: _____

Date of Birth: _____

Email Address: _____

Cell Phone: _____

Signature: _____

Date: _____

<u>Practice use only</u>

Patient NHI: _____

Photo ID: _____

Staff Member: _____

Date: _____